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Making History Critical: Recasting a History of the “Management” of the British National Health Service

Abstract

Purpose: This article explores a possible discursive history of NHS ‘management’ (with management, for reasons that will become evident, very much in scare quotes). Such a history is offered as a complement, as well as a counterpoint, to the more traditional approaches that have already been taken to the history of the issue.

Design/methodology/approach: Document analysis and interviews with UK NHS Trust Chief Executives.

Findings: After explicating the assumptions of the method it suggests, through a range of empirical sources that the NHS has undergone an era of administration, an era of management and an era of leadership.

Research limitations/implications: The paper enables a recasting of the history of the NHS; in particular, the potential for such a discursive history to highlight the interests supported and denied by different representational practices.

Practical implications: Today’s so-called leaders are leaders because of conventional representational practices – not because of some essence about what they really are.

Originality/value: The value of thinking in terms of what language does – rather than what it might represent.

Keywords: Performativity, leader-manager-administrator, power, control, language

Introduction

There is a widely received history of management in the English National Health Service (NHS) that many who have worked in health care since the 1970s or 1980s still tell. Similar tales are also in the academic literature, and widely told to students. Other health care systems across the world will doubtless have similarly widely-received histories. In brief the English story runs (more or less) as follows:

From the establishment of the NHS in 1948, hospitals were ‘traditionally administered bureaucracies ... [so they had] an administrative hierarchy that ran parallel to the medical hierarchy’: (Sausman, 2001); hospitals were run by a so-called lay administrator, a matron, and the chairman of the medical staff committee. The first major change to this model came in 1974, when consensus management was introduced. Under this system, hospitals (and other NHS services) were managed by teams consisting of a ‘full-time Administrator, Nurse, Community Physician and Finance Officer, with the addition of two part-time clinicians (one hospital consultant and one general practitioner)’ who had to agree upon a course of action in order for it to get implemented (Harrison, 1982). Thus, between 1948 and the early 1980s, the administrators of the NHS acted primarily as ‘diplomats’ in that they were ‘agents for physicians in a passive alliance, facilitating their practice by solving problems, smoothing conflicts and generally maintaining the organisation’ (Harrison, 1988). Then came the publication of the *NHS Management Inquiry* in 1983, which recommended the introduction of a ‘clearly defined general management function throughout the NHS’ (DHSS, 1983). This ensured that managers (not administrators) were put in place at all levels of the NHS. The extent to which these new managers were really “in charge” (especially of doctors) is a matter of dispute, but the subsequent emergence of competition in the 1990s encouraged these

managers (and some doctors, who were persuaded, albeit with mixed success, to get involved with management) to have an increasingly corporate outlook. Finally, while the market was replaced by supposedly more cooperative forms of working under New Labour (though these cooperative arrangements were supplemented by the national performance framework, star-ratings, and other regulatory mechanisms) NHS leaders – whether doctors, nurses or professional ‘managers’ – became what Davies and Harrison claims they still are today: ‘agents of government [rather] than ... facilitators of professionally driven agendas’ (Davies & Harrison, 2003, p.647). Such ‘leaders’ have, by and large, generally been considered to relatively successful in reining in the former excesses of medical freedom and licence.

I do not imply that the above account is wrong in a strong sense (though of course, any account is necessarily always a partial telling of the tale). For example, it is a tale told from the administrators’ managers’ leaders’ point of view. It would certainly be possible to write an account from the traditional point of view of health care professionals – one which would undoubtedly emphasise more how contested the process was; how contingent on the outcome of various power dynamics. However, the aim of this paper is both to complement and to problematize any single sort of historical account. It does so by producing a discursive history of NHS ‘management’ (with ‘management’, for reasons that will become apparent, quite definitely in scare quotes). Such a discursive history might run as follows:

Since the establishment of the UK National Health Service (NHS) in 1948, there have been a range of shifts in the way that its organizing practices have been represented. In the first few decades, administration was the more or less unexamined term for talking and arguing about how certain things got done in the NHS. Until the early 1980s, therefore, people referred to as administrators generally held quite prestigious jobs (and were mostly men). However, by the

end of the eighties, NHS workers called administrators had become what they remain today: relatively poorly paid (and mostly women), while manager had turned into a title that conferred substantial status. And especially after New Labour came to power, up until today, similar activities were/are increasingly articulated in the language of leadership. Indeed, by the end of the last century in the NHS, perhaps it was not too much of an exaggeration to claim that ‘we are all leaders now’, (Ford & Harding, 2007) in the sense that under New Labour, a desire to be (known as) a leader had become an aspiration held widely in the NHS – not merely by (those who were at one time called) lay administrators – but also by many clinical professionals (Martin and Learmonth, 2012).

For some of those who hold to this history, perhaps these sorts of changes in the dominant terms used are assumed merely to mirror the different practices seen in the NHS over the last 70 years (though commentators such as Davies and Harrison cited above do acknowledge a certain significance to the semantic shifts). However, while terms like leadership, management and administration might well be the names for different things in the world, what this essay emphasizes is that such words also function as discursive resources, discursive resources that in themselves have fueled change. Grey observes that:

the ascription of the term ‘management’ to various kinds of activities is not a mere convenience but rather something which has certain effects. The use of words is not innocent, and in the case of management its use carries irrevocable implications and resonances which are associated with industrialism and modern Western forms of rationality and control (Grey, 1999, p.557).

A central claim elaborated throughout this essay is that the different resonances associated with administration, management and leadership have represented important means by which contrasting normative ideas about the way healthcare should be organized have come to be naturalized. So rather than assume that language merely reflects reality, this paper demonstrates how such discursive resources ‘are simultaneously the grounds, the objects, and the means by which struggles for power are engaged in’ (Currie & Brown, 2003, p.565). In other words, the focus of this paper is not so much upon what administration, leadership and management are (and have been), as on what these terms do (and have done) with reality and to reality (cf. Gond et al, Learmonth, 2005; Learmonth and Morrell, 2016).

A range of empirical materials will be examined. These include professional journals read by hospital administrators in the early years of the NHS up to and including the 1960s; interviews that, in part, look back to this period (though they were conducted with NHS trust chief executives in 1997 and 1998 – at the start of New Labour’s term of office); and finally contemporary policy documents. The intent of the analysis is to nurture critical reflection upon how changes in the dominant language for organizing the NHS have rendered it intelligible and contestable in different ways. Furthermore, by exploring historical changes discursively, I particularly seek to problematize the assumptions of continuity and progress that are implicit in many of the received histories of NHS management. As we shall see, the discursive approach tends to stress some of the discontinuities – between, for example, the welfarism of the kindly administrators in the 1940s and the tough management job that chief executives had come to represent themselves as doing by the 1990s. There is a particular emphasis, too, upon how the terms administration, leadership and management have been deployed by (people known today as) NHS ‘managers’ (and also ‘leaders’) in struggles with medical staff (although any

distinction between ‘leaders’ and medics is becoming increasingly precarious) over power and legitimacy.

The paper proceeds as follows. An introductory discussion of the discursive method used in the analysis is followed by the presentation of empirical materials relevant to what I represent as three more or less separate eras – the era of administration, the era of management and, finally, the era of leadership. I conclude the paper with thoughts about how this approach to the historical analysis of the twentieth century NHS contributes to how we might understand the contemporary NHS.

An Approach to Discursive History

The primary theoretical inspiration for exploring the significance of words like ‘leadership’, ‘management’ and ‘administration’ comes from a reading of Jacques Derrida, a thinker whose ideas are of particular value in analyses concerned with the relationship between language and the world to which (we might assume) language refers. For Derrida, in a radicalization of John Austin’s *How to Do Things with Words*, language never only states the way things are, it is also always performative – where performative language, is language that ‘does something, in actuality, in reality, with reality’ (Royle, 2000) p.9. And it is Derrida’s radicalized version of Austin’s ‘speech acts’ theory that I use to understand the words ‘leadership’ ‘management’ and ‘administration’ as performative.

Austin referred to those speech acts he considered merely to set out a state of affairs as constative; but his interest was in speech that, in and of itself, does things – using the term performative for such utterances. Austin’s concern, as he put it, was with the: ‘performance of

an act in saying something as opposed to [the] performance of an act of saying something' (Austin, 1962) p.99. Instead of considering a statement such as 'there is a bull in the field' (1962, p.32) primarily as a constative statement – in terms of what it describes about the scenery – Austin privileged what the statement does, asking whether it might be a warning, a request, a complaint and so forth. Derrida's thought has a number of affinities with Austin's in that they both unsettle the traditional image of communication as the straightforward transportation of meaning from one speaker to another. Derrida welcomed Austin's move as an antidote to ideas that underpin, among other things, traditional understandings of empirical inquiry:

Austin was obliged to free the analysis of the performative from the authority of the truth value, from the true/false opposition....The performative is a 'communication' which is not limited strictly to the transference of a semantic content that is already constituted and dominated by an orientation toward truth. (Derrida, 1979) p.190. However, their ideas diverged when theorizing how words do what they do. Austin argued that the 'force' of a performative is provided primarily by the authentic intentions of the speaker, usually allied to the context in which speech is uttered and the lack of ambiguity in the formulation used. So, for Austin, a priest in a wedding ceremony who says: 'I pronounce you husband and wife' would be uttering a speech act which would be successful in doing something (marrying the couple) because of the intentions of the priest and the couple involved – along with the context and the unambiguity of the formulation. In opposition to Austin, however, Derrida made clear that for him the force of a performative is not intention, but citation. The notion of iterability or citation is what for Derrida underlies any 'successful' performative:

Could a performative utterance succeed if its formulation did not repeat a 'coded' or iterable utterance, or in other words, if the formula I pronounce in order to open a meeting, launch a ship or a marriage were not identifiable as conforming with an iterable model, if it were not then identifiable in some sort of way as a 'citation'. (pp.191-2)

To continue the example of a wedding, Derrida is pointing out that a priest can only marry someone because the words spoken are recognizably part of a marriage ceremony: 'I pronounce you husband and wife' must be a citation for it to marry a couple. Citation, Derrida argued, is prior to intention; indeed, it is a condition of possibility for intention to operate. This is not to deny that intention and context have a role in speech acts, but, as Derrida argued, intention and context 'will no longer be able to govern the entire scene and system of utterance.' (p.192)

Following Derrida, then, if terms like management, leadership and administration do things in the world, they operate, not primarily because the intention of the speaker successfully governs the action of speech, but because these words, in some sort of way, are citations – quotes from previously existing sources. Indeed, it is surely uncontroversial to claim that these terms have become conventional categories to use in representing the organization of public services like the NHS, such that it is hardly possible to make intelligible statements in the field without recourse to these terms. Derrida's point is that the effects on the world of these terms rely upon the accumulation of academic research, official reports, routine talk and so on in which these terms are deployed. And, as we shall see, these terms did different things in different eras of NHS history because they came to accumulate different conventions surrounding their meanings.

The Era of NHS Administration

The main empirical materials in this section are derived from the May editions of a journal called *The Hospital* (TH) which was sampled between 1946 to 1948, 1956 to 1958, and 1966 to 1968 (cf. Learmonth, 1998). During this period, TH was the official publication of the Institute of Hospital Administrators (IHA), a body to which the vast majority of hospital administrators belonged. The IHA was primarily a professional membership organization, setting examinations for apprentice administrators, as well as publishing TH in order to meet its members' continuing education needs. Today incidentally, the successor body to the IHA is known as the Institute of Healthcare Management (IHM) – see <http://www.ihm.org.uk/home> – a change of name not without significance, of course, for the arguments in this paper. In any event, the study of TH was conducted not so much to enable an understanding of the formal arrangements and official reports of the time, rather it was intended to enable inferences to be made about the ways in which the people called administrators thought and acted in this period.

In this regard, during the 1940s and 1950s, the vast majority of the material in the texts was descriptive and prescriptive, articles concerned with what might be described, not entirely unfairly, as recipes for the best way to do things, in the sense that the guidance seemed to have been meant simply to be followed. In other words, complex abstractions were very rarely debated, nor were sophisticated arguments developed; indeed, there was a marked reluctance to engage with anything that sounded 'complicated and American in its high falutin' approach' as one commentator put it. It seems then that both what the job of the administrator consisted of, and how it should be carried out was assumed to be clear and uncontroversial.

What was also clear in the early part of this period was that: 'the chief officer of the hospital [is] usually the Medical Superintendent ... the secretary ... controls the business side'. Indeed,

there was never any discussion of the potential for conflict between the business and medical ‘sides’, and any possible question about whether or not the administrators’ deferential situation was appropriate seems not to have occurred to them. Therefore, the overwhelming majority of articles in the 1940s and 1950s were concerned with minutely detailing recommendations about the best course of action for the conduct of day to day arrangements. Matters labelled, for example, ‘superannuation’; ‘Lunacy Act 1890 section 287 “Out-county” changes’; ‘hospital planning – patients’ accommodation’; ‘mental health service: changes proposed under the Bill’; ‘hospital cost accounts: application in practice’ all had several pages of dense typeface devoted to them – the articles concentrating on thoroughly elaborating the minutiae of the technicalities involved with each issue.

However, there were a few more conventionally reflective passages. One such, an editorial comment from 1948 that discussed the work of the recently established Institute of Management, is of particular interest for the arguments advanced in this paper:

Speaking at the recent Annual Conference of the Institute of Hospital Administrators, Mr. F.A. Lyon mentioned the difficulty of evaluating the content of the respective spheres of administration and management. His conclusion was that a complete separation could not be made, but he made a point of mentioning the danger of laying excessive emphasis on the technical aspects of hospital management, saying that attention must be given in the courses of study of bodies such as the Institute of Hospital Administrators, to the study of “the pure science and art of administration”.

Here, in contrast to today’s assumptions, the comparison between management and administration seems to imply that administration was regarded as a ‘higher’ discipline than

management; management being about mere technical matters. Indeed, from the wider literature on the history of management, it seems possible that in the 1940s and 1950s, ‘management’ still had (for some) undesirable cultural associations that linked it with being ‘in trade’ or with household management (Mant, 1982); associations that appear to have been occluded by the language of administration – an art that was practised at that time by top (Oxbridge-educated) civil servants. It is worth noting as an aside that a preference for administration rather than management is still discernable today, surviving as it does in formulations from this period. A notable example is that a higher business degree is still widely known as an MBA: Master of Business Administration.

However, perhaps most striking for me as a contemporary reader was the emphasis throughout the texts that administrators needed to remember the nature of the service they were in and the implication that this had for their personal conduct. For example, in a conference speech a newly appointed Regional Hospital Board Chairman contrasted those services that depended ‘upon mechanical efficiency’ with human social services (including health care) which:

come under a different heading ... for in that field what is required is not mathematical efficiency but a sympathetic understanding. It is not only what you do that is important; it is the way in which you do it; it is the approach; it is the recognition that you are dealing with human beings and qualities which are required in the administration of that service are something beyond mere intellect; it is the right sort of human emotion.

He went on to describe the personal qualities of a Regional Chairman, who will require:

the patience of Job; the kindly spirit of a saint, the deafness that will prevent him hearing all the things which might disturb him and a sight which will enable him not to see the things which are better not seen.

This early emphasis on kindness had disappeared , however, by the 1960s' editions of TH. For a start, overt conflicts between the business side and the medical practices of the hospital had emerged. For example, discussing how complaints against medical staff should be handled, one article asks: 'should the administrator be involved?' The answer is resonant with Harrison's claim that administrators were diplomats who smoothed out problems for doctors but were essentially subservient to them:

Yes. If he is a wise administrator his involvement will appear indirect ... If the medical staff close their ranks against him then there is something wrong. The secret is to build one's personal relationships before the incidents occur. ... One should deal with consultants personally. An occasional visit to the operating theatre and a cup of coffee in the surgeon's room is a worthwhile practice.

It was also clear from the pages of the 1960s journals that many administrators were now studying for college- or university-based management qualifications (importantly, such qualifications were in management as opposed to administration). These qualifications would have been in addition to their basic IHA examinations, but a number of projects originally conducted for such qualifications were published in TH. Perhaps, in part because of the influence of management education (Hunter, 1988), though the term administration was still dominant, routine claims about their work were also starting to be made in the language of management. One article, for example claims that 'all senior staff of whatever category are

now thought of as managers', 7 and even the nursing profession were said to be putting 'faith in intensive training in management' 8 for their senior staff.

In other words, a tension – between traditional ideas about administration and what, even 10 years previously might have been called 'high falutin' management – was beginning to emerge. This can be seen especially clearly in a debate about the possibility of chief executives for hospitals that found its way into TH. Two reports, *Administrative Practice of Hospital Boards* in Scotland (Scottish Health Council, 1966) and *The Shape of Hospital Management in 1980?* (King Edward's Hospital Fund for England, 1967) had both recommended the appointment of a General Manager to head district hospitals. Such proposals were opposed by doctors at the time in the most vehement terms. As one letter in the *British Medical Journal* put it:

The lay take-over of hospital administration by all-powerful general managers, most of whom would be "lay," would eventually reduce the status of medical staff to the level of all other groups of hospital workers. ... The interference with professional freedom and the doctor-patient relationship ... would unquestionably ruin our health service for all time (Blundell & Lowry, 1967)

Perhaps predictably, given its cautious attitude to working on complaints against doctors the commentary to be found in TH on the chief executives debate was short and deferential:

The working party [that had prepared the 1967 King's Fund Report] felt that doctors were non-managers and did not like being managed, but might be prepared to hand over middle management chores. 9

Still, there was a (gentle) insistence on using the language of management, which contrasts rather starkly with terms like ‘lay ... hospital administration’ preferred by the BMJ’s correspondents. But in any case, both reports were quietly ignored by the Labour government of the day, and hospital administrators were officially to remain administrators for almost another 20 years. Indeed, although a number of significant changes to NHS organizational arrangements were made in the 1970s – in particular Area and District Health Authorities were established, and with them, as we have seen, so-called consensus management.¹⁰ However, administrators remained administrators and what representing these workers in the language of administration successfully did was to keep them in subordination to doctors throughout this time. Things were set to change in the 1980s, however, when proposals were made again to create a new cadre of people called managers in the NHS. It is to these 1980s proposals, and their effects, to which we now turn.

The Era of NHS Management

In 1983, at the request of the Secretary of State for Health and Social Security, a team of businessmen headed by Roy Griffiths produced the NHS Management Inquiry – a document that was widely read as recommending the adoption of ‘a clearly defined general management function throughout the NHS’ (DHSS, 1983) p.11. As we have seen, similar proposals had been made in the 1960s with no effect. This time however, within two years, the Thatcher government (the prestige that Thatcher accorded to business people is significant here) announced that general managers had been appointed at all levels of the NHS; albeit in the teeth of bitter opposition from many healthcare professions (Timmins, 1998).

Though at the time, some commentators were less than enthusiastic, many of the individuals who came to be called managers were themselves deeply committed to what they believed were the new ideals of general management (Strong & Robinson, 1990) even though about 70% of the (supposedly new) managers had previously been known as administrators (Petchey, 1986). And the officially sanctioned rhetoric by the late 1980s had come to be that the NHS had been ‘transformed from a classic example of an administered public sector bureaucracy into one that is increasingly exhibiting qualities that reflect positive, purposeful management.’ (Best; in Flynn, 1992, p.47).

The shock waves caused by the *NHS Management Inquiry* were profound, so even though the interviews reported here were conducted in 1998 to 1999, it was very evident that the informants were still conscious of the significance of this change – the change from being known as administrators to being called managers. The interviews were with 16 NHS trust chief executives in hospitals in the north of England and were intended to investigate how such individuals made sense of their professional world. They were unstructured, qualitative interviews, framed simply by an opening question – ‘what do you see as the heart of your job?’ – continuing by ranging across a wide set of topics in a fluid and informal manner as the participants themselves chose.

As a preliminary to the interviews, each respondent was asked to describe their professional background. Of the 16 interviewees, one was a clinician, two were accountants and one had come in to the NHS from another sector in the last ten years. In the case of the other 12, exchanges such as the following two excerpts were typical of the start of the interviews:

Q: If I could just ask you what your professional background is

Well administration, health service administration

Q: Right right, good good. OK first question then, I'd like to ask you to describe the heart of your job

Leadership

Q: Right right fine ha ha. Tell me about leadership

Well we, er I, am personally accountable for the managerial performance of the organization, the organization consists of three thousand people and to achieve my objectives I physically can't do it myself; when I was an administrator I had tasks to do which I did myself but as a leader you inspire, lead, manage others to do the work

Or:

... my professional background? I mean I came into the health service as, at that stage, a career administrator, straight from university; on to the administrators' training scheme and if you like moved into management, as management developed in the NHS, from an administrative background ...

The opposition between administration and management was not something that occurred merely at the start of the interviews, though its striking regularity at the start of the interviews

was what prompted a search of the transcripts for other examples. In the course of the interviews, the radical differences claimed to exist between administrators from the past and current chief executives were sometimes elaborated at length:

... just as a caricature I would make the observation that many administrators in the '70s and '80s, the top ones, were employed mainly, well mainly, for their brain power per se. As I say, a lot of them were intellectuals, Oxbridge graduates and so on; and the current generation of chief executives are also very clever people but they have their skills are now rooted in common sense and people skills. So it's not just about administering legal or financial affairs which require a certain set of administrative skills and brain power it's more to do with empowering people and leading people and having those skills. And I've many a time come across in my career people whose intellect has got in the way of their common sense, people skills. So it is they're now different animals ...

Thus, a belief in the essential inferiority of administration and the concomitant prestige of management had clearly become established by this time. This relationship between the two terms can also be seen in the fact that when the term administrator occurred (outside ruminations about the past) it was typically deployed as an insult. As in this next excerpt, for example, where a chief executive was talking of the top management team immediately before her appointment (including the former chief executive). According to her, these people had been unable to cope with the new demands of partnership working, such that:

... there [had been] no radical or strategic thinking enough to do that sort of work; em [name of hospital] used to be peopled by a bunch of administrators basically ...

And, according to another respondent, administrator was a term that could also be used to similar disparaging effect by medical staff:

... when consultants actually want to diminish what I do they call me an administrator.

Q: Yes, I remember that from the early eighties.

Still do, still do, because that's about your job is to support what we do; accepting that I'm actually a chief executive gives me a leadership position ...

By the 1990s then, in contrast to the 1960s, it seems that words associated with management had come to do things, in the sense that these words constructed and legitimated an organizational world in which chief executives felt they had supremacy. Administrator, on the other hand, had come to do things that undermined the prestige and authority such people would like. These sorts of insights are reinforced and further explained by the next excerpt in which some of the history of the power relations between doctors and managers (or should we say administrators?) are represented in more detail:

... earlier on in my career where the successful administrators in the sixties and seventies were those which were actually able to facilitate what the doctors wanted to do that's how you were judged.

Q: Right, not influence it at all?

Well you might influence it provided you didn't tell people you were influencing it; it was actually quite a clever game - you let the doctors think that it was their idea but actually your skills were in terms of making it happen and using the process or whatever. Of course the real skill was that you didn't make happen those things that you didn't want to make happen, but if you made nothing happen then you were not a good administrator and you would alienate the doctors and then you would be unsuccessful ...

As we have already noted, prior to the NHS Management Inquiry, administrators were widely seen (by themselves and by the medical staff) as doctors' support workers. Any prestige they might have had arose from their success in fulfilling doctors' wishes rather than from the activities they chose independently. But one way of reading this excerpt is to see it as an implicit statement that the re-labelling from administrator to manager that was licensed by the NHS Management Inquiry was not one that necessarily altered the substance of administrators'/managers' activities. Senior administrators of the past and chief executives in the 1990s, could be represented as carrying out much the same activities – according to this excerpt, making things happen, more or less as they felt appropriate. However, individuals called administrators had to make sure that what they did appeared to be done in the service of others. Their self-identity was therefore continuously defined as subservient and secondary – the need to be able to subvert the apparent relationship by playing 'quite a clever game' no doubt merely reinforced this identity (Learmonth and Humphreys, 2011). Of course, the implicit corollary to the status of the administrator is that what being called a manager does is legitimate the (so-called) manager acting in a way that is independent of 'what the doctors want'; thereby radically changing the nature of their respective senses of self.

Thus, the discursive change from administration to management can be understood as a resource to be called upon in struggles for power and legitimacy. In the mid-1990s, this resource often seems to have been used by deploying the term management as an apparently uncontroversial and routine way of talking about all sorts of activities. For example:

... One of the things that I learnt was that we often expect too much of doctors in terms of their ability to manage and also their capacity to manage and their commitment to do the things that managers have to do because their livelihoods depend on it – doctors don't [have to do these things]. And I felt that, [and] the medical director he felt, that the emergence of clinical governance was an opportunity to refocus the doctors' role on clinical management, leadership and the management increasingly of clinical practice informed by evidence, rather than on the management of service delivery and staffing budgets and so on ...

In this excerpt the speaker deploys the term management in at least two senses. There is the more or less conventional contemporary sense of management as the distinctive occupational functions of certain people identified as professional managers by their job titles. Management in this sense is represented as 'the management of service delivery and staffing budgets and so on', which the speaker believed doctors need not do. However, in juxtaposition to this, he also uses the same term, 'management' to represent rather different functions, functions he considers to be legitimate medical duties: 'clinical management, leadership and the management increasingly of clinical practice informed by evidence'. But it is not implausible to believe that what he is talking about here could equally have been represented in more traditional language, as part of the ordinary, routine duties that senior medical staff have always carried out in modern times; that is such duties could have equally been described without recourse to the term management.

The next excerpt gives a parallel example of this sort of deployment. It occurred after I had asked the respondent to explain (what for me was) her intriguing use of the term ‘consultant-managers’:

Q: do you mean all consultants are managers or do you mean that there are certain consultants who are managers like clinical directors or whatever?

Okay, I mean both. All consultants are managers em; not all consultants would recognize that or recognize the implications of that as readily as others do but they all manage resources, they all manage their time, manage junior medical staff and have therefore particular accountability for them ...

One way of interpreting what was being attempted in both these excerpts is that it was a re-presentation of medical work as managerial work. The significance of the change from the point of view of the chief executive being that if managerial language successfully colonises doctors’ routine talk and thinking, they are likely to come to understand their own identities as managerial, at least in part. Furthermore, the logic of such an understanding tends to imply that doctors should then be accountable to the professional expert in management (i.e. the chief executive). And not only accountability was at stake, important as it might be. Another implication of the discursive change from administration to management is that more traditional considerations for the NHS, especially ones based on welfarism, caring and compassion (values consistently stressed in the 1940s and 1950s) can plausibly be played down and rendered subservient to the tough job of ensuring good management.

The Era of NHS Leadership

But did the discursive change from administration to management have the effects on medical staff's allegiances that was seemingly desired? It seems that its effects were limited. Perhaps, in part, this was because for individual chief executives, even those who have never been administrators themselves, the discursive history of the term manager in the NHS always has the denigrated shadow of the administrator behind it: people called managers in the NHS are intrinsically vulnerable to being cast as 'mere' administrators. One might speculate then that it was the negative associations accumulated by management and administration by the end of the 1990s that underlay the popular and officially sanctioned turn to leadership that occurred at that time, not just in health but in many other parts of the public sector (Ford, 2004). It may well also account for other discursive shifts in the NHS that reduced the need to deploy the term manager and management, especially in clinical matters. Prominent examples from the early New Labour era included senior nurses being described as modern matrons or nurse consultants (rather than as nurse managers) and the control of clinical activities being officially designated clinical governance (rather than clinical management).

At the beginning of New Labour's first term of office (when the interviews were conducted) the discourse of leadership was clearly available to chief executives in the NHS in the sense that the word was regularly mentioned – in fact, it occurs in most of the excerpts used in this paper. However, whereas management was made intelligible by opposing it to administration, at this stage, leadership was not generally constructed through sharp distinctions with management – the two terms seemed to have been used more or less as synonyms. But this situation seems to have changed by the close of the century: as Parker has pointed out, under 'New Labour ... management itself ... [was] beginning to go out of fashion (now being discursively articulated

as something rather like administration) and leadership ... [was] the new panacea' (Parker, 2004). Thus by 2002, on the National Nursing Leadership's Project web site, a government minister could say:

Good clinical leadership is central to the delivery of the NHS Plan. We need leaders who are willing to embrace and drive through the radical transformation in services that the NHS requires. Leaders are people who make things happen in ways that command the confidence of local staff. They are people who lead clinical teams, people who lead service networks, people who lead partnerships, and people who lead organisations. 1 National Nursing Leadership Project. 2002. At <http://www.nursingleadership.co.uk> [accessed 15.5.02].

Such statements about 'clinical leadership' bear comparison with the respondents' talk of 'clinical management' cited earlier. Both sorts of statements were no doubt intended to represent the world as it is: nurse 'leaders are people who make things happen'; consultants 'manage resources, they all manage their time, manage junior medical staff'. But again, understanding either statement only as empirical claims overlooks (and thereby reinforces) what such words do. Deploying leadership in this way seems more or less calculated to have the effect of 'regulating employees' "insides" - their self-image, their feelings and identifications' (Alvesson & Willmott, 2002) p.622. Indeed, throughout the public sector, the official endorsement of leadership to represent organizational practices can be interpreted in part, as a growing recognition that calling activities 'leadership' does more than calling them 'management' (and, it goes without saying, more than 'administration') in terms of encouraging individuals to identify with policy aims. This is because leadership's relative lack of negative associations (at least its lack of negative associations so far – who knows how things will

change) made leadership a term likely to be inoffensive, perhaps attractive to many health care professionals as the new central resource in the construction of their self-image.

By the end of the Blairite period then, leadership for many in the NHS had become ‘a way of being’ (Ford, Harding & Learmonth, 2008) p.4, rather than merely a job. But it was a way of being that was disciplinary, in the sense that in order to maintain this sense of self individuals had to conform to the demands of those who define what good leadership is. For according to the above excerpt, being a good leader is not just about romantic notions such as an ability ‘to drive through ... radical transformation in services’. Axiomatic to being a ‘good’ leader is also compliance with official definitions of what ‘the NHS requires’.

In the last few years then, rather than managerialism being the dominant way people with power think about their influence, what O’Reilly and Reed (2010, p.962) call ‘leaderism’ has taken its place. As they argue: ‘whereas management necessarily involves the conundrum of aligning principal and agent, the change in discourse to leadership resolves this conundrum through re-definition by making the issue the establishment of a passion for a common goal between leaders and led’ (2010, p.962). Indeed, the word leadership is now used for pretty much any kind of activity that is thought of by officials as “positive” so that it is becoming an almost meaningless term. Indeed, the rhetoric is so widespread that as Morrell and Hewison (2013: 70) in the context of the Darzi report show ‘it becomes impossible to see an alternative to “leadership” ... leadership is, seemingly, anything and everything.’

Discussion and Conclusion

It follows then that many activities carried out by NHS staff today ‘are’ management (or administration, or leadership) in the sense that they are currently given these names. However, the contribution of this historical analysis is to show that these same activities are always potentially not management or not leadership in the sense that they can always be called by other names – and, as we have seen, they have been given different names in times past. What a particular activity ‘is’ does not rely on some essence within it – things like leadership, management or administration (indeed all categories through which we experience the world) are human creations, a reflection of conventional ways of apprehending the world and not a reflection of what the world is ‘really like’. What leadership, management and administration have come to represent therefore has been made to appear self-evident through an inescapably arbitrary process of inclusion and exclusion of significance, a process held together only by convention and power. It is interesting to note in this respect, how the interview excerpts used resonate with definitions of management and administration like the one provided by Hughes:

Public administration focuses on process, on procedures and propriety, while public management involves much more. Instead of merely following instructions, a public manager focuses on achieving results and taking responsibility for doing so (Hughes, 1994) pp.3-4

So the problems with seeing leadership, administration and management as more or less unproblematic terms representing different things in the world is that typically, in both practitioner and academic accounts, management (and now leadership) are preferred – the terms are hierarchical. Calling certain practices administration, others management and yet others leadership is not simply to name them, the practice does things to them, most obviously perhaps, in the sense that it values them in different ways.

What I want to argue then is that one way of doing historical analyses of organizational phenomena is to focus on the effects of dominant discourses rather than whether these discourses were ‘true’ or not. In this case, constructing a certain sense of self is something that any appeal to be an administrator, a manager or a leader does; something likely to be missed if such words were to be read merely as potentially true or false claims about the changing nature of workplace duties. Understanding oneself as a manager (not an administrator) or as a leader (not a manager) provides positive cultural valences that enable one to construct an affirmative reflexive understanding of self. It is good to be able to think of oneself as a radical and strategic manager or an empowering leader – not as (merely) administering something like paperwork. Furthermore, and relatedly, being known as a leader (and not a manager) is more likely to construct the sort of public image that others may see as legitimate – and to which they will therefore acquiesce. As (Clarke & Newman, 1997) have pointed out, the ‘discourse of managerialism ... is part of the process through which “administrators”, “public servants” and “practitioners” come to see themselves as “business managers”... “strategists”, “leaders” and so on.’ (p.92)

All this is important because it may well not be in the interests of health care professionals to define themselves as leaders or to use the language of leadership – as attractive as it may be on certain levels so to do. After all, identifying as a leader involves conformity to the wider logics of leadership: an acceptance of the legitimacy of the top leader’s (the chief executive’s) right to lead, as well as an acquiescence to the elites who get to define ‘what the NHS requires’. Doctors who insult chief executives by calling them ‘administrators’ (are there still people who do this?) seem to be aware of this particular danger. Indeed, I would go so far as to argue that the currently taken-for granted status of the language of leadership might well constitute a form of what Pierre Bourdieu has called ‘structural symbolic violence’; the resultant domination is

‘something you absorb like air, something you don’t feel pressured by; it is everywhere and nowhere and to escape from that is very difficult’ in (Catley & Jones, 2002), p.28.

So what can academics and other commentators do in the light of this debate, faced today with the hegemony of the language of leadership for the representation of public organizing activities? On the one hand we cannot use terms like leadership, management and administration without their automatic appropriation, by one side or another, for doing things in the conflicts over language to which I have drawn attention. On the other hand, we must use these sorts of terms to make ourselves intelligible. One possibility for a research agenda that takes these problems seriously would proceed not by relativising terms such as leadership, management and administration so that any distinction is denied, but rather by the detailed scrutiny of the precise points at which distinctions are invoked so that easy and comfortable assumptions about their implications cannot be made. We might examine what invoking distinctions do rather than what the distinctions are. And in particular perhaps, examine whose interests are favoured and whose denied when strong distinctions are made to appear to be plausible.

It is also important to build these kinds of perspectives into our teaching to enhance curricula. It is perhaps a little too easy to present historical perspectives without a discursive content. In my own teaching practice, I have been surprised by just how quickly and readily many mature students who are health care professionals or otherwise involved in health care relate to these kinds of perspectives. What we call things matters on a fundamental level (Learmonth, 2009) but so often what we call things just slips by unnoticed. I hope this article will make a modest contribution to making people reflexive about the terms they use.

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